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| **Casual Patient Form** Onslow Medical Centre | | | | | |
| **Title**: Mr Mrs Ms Miss Mast Dr | | | **NHI Number:** | | |
| **Family Name:** | | | **First Name/s:** | | |
| **Gender:** M/ F/ U | **Date of Birth:** | | **Country of Birth:** | | |
| **Physical Address**: | | | **Mobile Number:** | | |
| **Your Email:** | | | **Your Current GP Details (NZ only):** | | |
| **Emergency Contact Name:** | | **Contact number:** | | | **Relationship to you:** |
| * I understand that any information provided by me will be confidential in terms of the Health Information Privacy Act. * I understand that if I do not meet the criteria laid out in the Eligibility Guide, I am not eligible for further services. * I understand Onslow Medical Centre is seeing me as a “Casual Patient” and will not be contacting me for any regular recall services such as Cervical Smears. This is the responsibility of my usual Doctor. * I understand that payment is required on day of consultation\*. * Any accounts extending past a 90 day period will be sent to a debt collection agency (unless prior arrangements have been made) and the costs associated with this will be added. * I authorise the Doctor to contact my regular medical centre for further information, should it be required. * Onslow Medical Centre reserves the right to vary this policy as it sees fit. * Please sign below to acknowledge your understanding of this policy and the implications of non-payment.   **SIGNED**: **Date**:  or  **SIGNED AUTHORITY**: **Date**:  **Relationship to Patient:**  *An authority is the legal right to sign for another person if for some reason they are unable to consent on their own behalf* | | | | **Which ethnic group do you belong to?**  *Tick those that apply*   * New Zealand European * Maori * Samoan * Cook Island Maori * Other European * Asian * Chinese * Indian * Other ethnicity (please specify below)     **\*If you were not born in NZ, please advise which of the following applies:**   * Citizen or Permanent Resident * Work Visa over 2 years * Work Visa less than 2 years * Visitor Visa * Student Visa * Other (please specify below)      |  |  | | --- | --- | | Admin use only | | | Visa / Passport sighted *(initials)* |  | | Visa expiry date (if applicable) |  | | |
| **WE EXPECT PAYMENT ON THE DAY FROM ALL CASUAL PATIENTS** (\*unless arranged by prior agreement) | | | | | |